# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Research Foundation The City University Of NY: EPO

Your Network: EPO

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | **K Health:** No charge<br>**LiveHealth Online:** $20 copay per visit |
| **Mental Health & Substance Use Disorder Services** | $20 copay per visit |
| **Specialist care** | $25 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Overall Deductible** | $0 person /<br>$0 family | Not covered |
| **Overall Out-of-Pocket Limit** | $5,080 person /<br>$12,700 family | Not covered |
| The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per person out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per person out-of-pocket limit.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. | | |
| **Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).* | | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | $20 copay per visit | Not covered |
| **Specialist Care** *virtual and office* | $25 copay per visit | Not covered |
| **Other Practitioner Visits** | | |
| **Routine Maternity Care** (Prenatal and Postnatal) | No charge | Not covered |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $20 copay per visit | Not covered |
| **Chiropractic Services** | $20 copay per visit | Not covered |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Acupuncture** | $20 copay per visit | Not covered |
| **Other Services in an Office** | | |
| **Allergy Testing** | No charge | Not covered |
| **Prescription Drugs** *Dispensed in the office* | No charge | Not covered |
| **Surgery** | No charge | Not covered |
| **Preventive care / screenings / immunizations** | No charge | Not covered |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Not covered |
| **Diagnostic Services** | | |
| **Lab** | | |
| Office | No charge | Not covered |
| Freestanding Lab/Reference Lab | No charge | Not covered |
| Outpatient Hospital | No charge | Not covered |
| **X-Ray** | | |
| Office | No charge | Not covered |
| Outpatient Hospital | No charge | Not covered |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | No charge | Not covered |
| Outpatient Hospital | No charge | Not covered |
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $25 copay per visit | Covered as In-Network |
| **Emergency Room Facility Services** *Your copay will be waived if admitted within 24 hours.* | $75 copay per occurrence for the first 1 visit | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Emergency Room Doctor and Other Services** | No charge | Covered as In-Network |
| **Ambulance** | No charge | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| Facility Fees | No charge | Not covered |
| Doctor Services | No charge | Not covered |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | No charge | Not covered |
| Ambulatory Surgical Center | No charge | Not covered |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | No charge | Not covered |
| Ambulatory Surgical Center | No charge | Not covered |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)**<br>*If readmitted within 90 days for the same or related condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.* | | |
| **Facility Fees** | $300 copay per admission up to $750 maximum per benefit period | Not covered |
| **Physician and other services** *including surgeon fees* | No charge | Not covered |
| **Home Health Care**<br>*Coverage is limited to 200 visits per benefit period.* | No charge | Not covered |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.* | | |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| Office | $20 copay per visit | Not covered |
| Outpatient Hospital | $25 copay per visit | Not covered |
| **Pulmonary rehabilitation** *office and outpatient hospital* | No charge | Not covered |
| **Cardiac rehabilitation** *office and outpatient hospital*<br>*Coverage is limited to 36 visits per benefit period.* | $25 copay per visit | Not covered |
| **Dialysis/Hemodialysis** *office and outpatient hospital*<br>*Coverage is limited to 10 visits per benefit period. Applies to Non Network.* | No charge | No charge |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | No charge | Not covered |
| **Skilled Nursing Care (facility)**<br>*Coverage is limited to 60 days per benefit period.* | No charge | Not covered |
| **Inpatient Hospice**<br>*Coverage is limited to 210 days per lifetime.* | No charge | Not covered |
| **Durable Medical Equipment** | No charge | Not covered |
| **Prosthetic Devices**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | No charge | Not covered |
| **Hearing Aids**<br>*Coverage is limited to 1 item per ear every 2 years.* | No charge | Not covered |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use a Non-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** | Not applicable | Not covered |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Not covered |
| **Prescription Drug Coverage**<br>**Network: *Base Network***<br>**Drug List: *National*** | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)* | | |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use a Non-Network Pharmacy |
|---|---|---|
| **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.* | | |
| **Tier 1 - Typically Generic** | $5 copay per prescription (retail and home delivery) | Not covered |
| **Tier 2 – Typically Preferred Brand** | $25 copay per prescription (retail and home delivery) | Not covered |
| **Tier 3 - Typically Non-Preferred Brand/Specialty Drugs** | $50 copay per prescription (retail and home delivery) | Not covered |

**Notes:**

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*



Questions: Visit us at www.anthem.com

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## Language Access Services:

# Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (800) 342-9816

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

**(TTY/TDD: 711)**

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**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 342-9816:

**Chinese(中文)：**如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(800) 342-9816。

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**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 342-9816.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 342-9816.

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**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (800) 342-9816.

## Language Access Services:

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (800) 342-9816.

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